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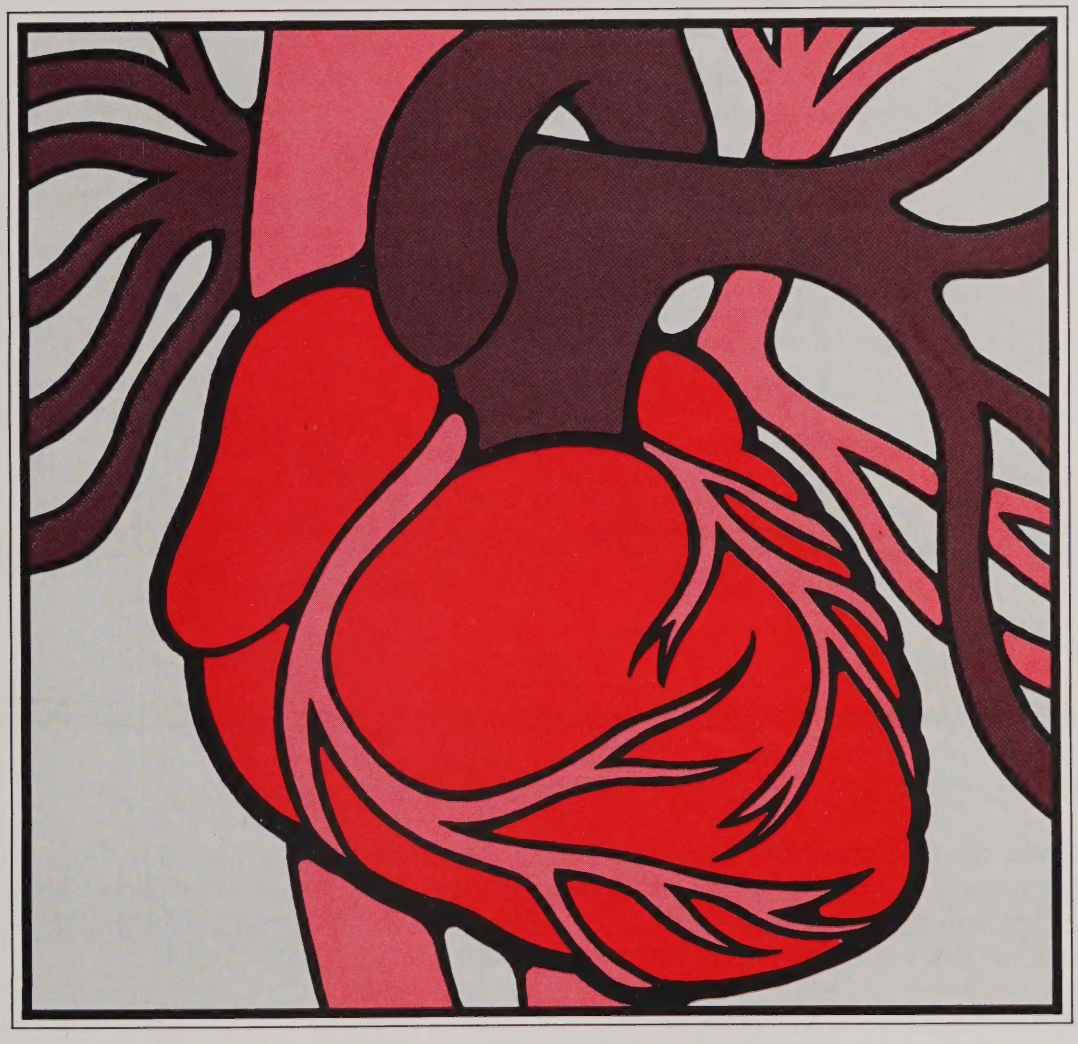

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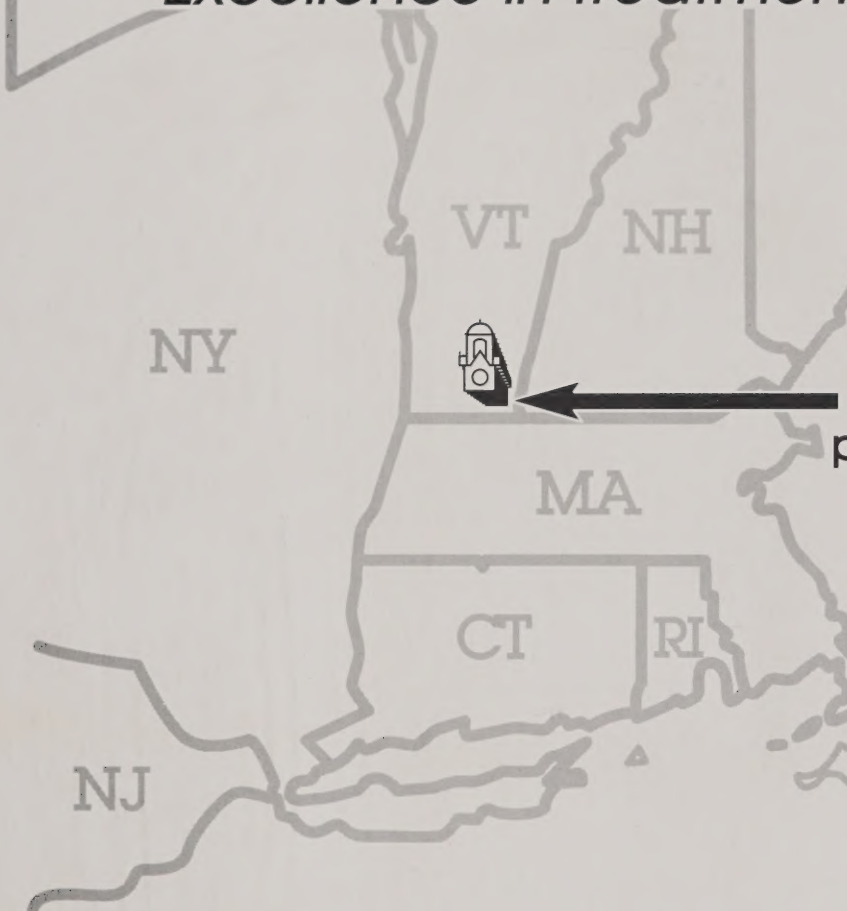

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THE
Hampden Hippocrat
NOVEMBER—DECEMBER 1992

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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HAMPDEN DISTRICT MEDICAL SOCIETY 1992-1993 SEASON

DISTRICT MEETING

PLACE: **SHERATON SPRINGFIELD**
Monarch Place Hotel
One Monarch Place, Springfield

DATE: Tuesday, January 26, 1993

BUSINESS MEETING: 6:00 p.m.

SOCIAL HOUR: 7:00 p.m.

DINNER: 7:30 p.m., SPOUSES ARE WELCOME!

SPEAKER: JOSEPH T. PAINTER, M.D., President Elect
American Medical Association

SUBJECT: AMA Faces The Issues

NOTE: If you must cancel your dinner reservation, please call the HDMS office before noon on January 26th. If the cancellation is not made, you will be BILLED for your dinner.

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From the Editors

We return to our review of medicine in the Pioneer Valley with this issue on Cardiology. We hope you enjoy the original contributions from Drs. Gianelly, Schweiger, and Wittenberg.

Do you have a bone to pick, an opinion to share, an alarm to raise, a story to tell? We have a spot for this called "The Last Word". When we don't hear from the readership, we feel obligated to fill the space ourselves. Consequently, you can raise the tone of the **Hippocrat** not only by your contribution, but by seeing to it that ours does not get printed. Where else can you have such a dramatic impact? ■

Brigid Glackin, M.D.
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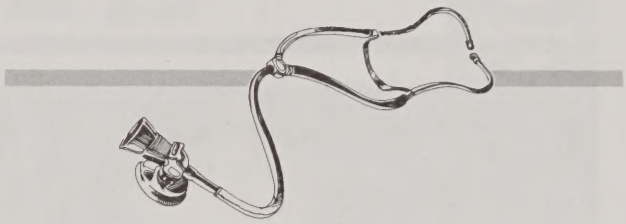

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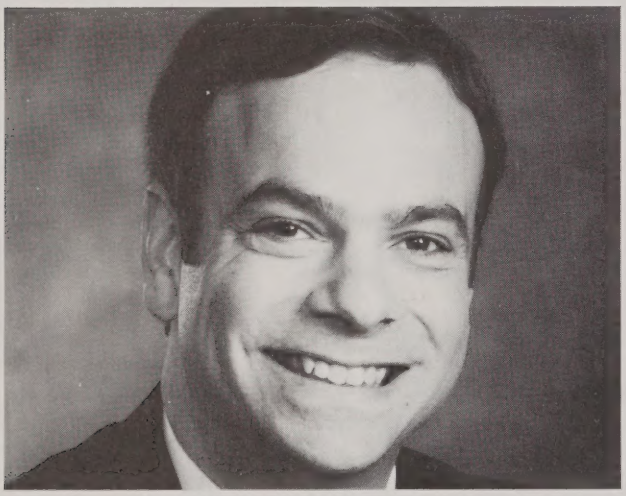
MMS: Planning for the 21st Century

As we approach the midpoint of the Society's year, it is important that the members of HDMS, and the Hampshire, Franklin, and Berkshire Societies as well, become familiary with processes already well underway at MMS which will help shape and steer the Society for years to come.



Robert V. Chircop, M.D., President

The MMS Council in May of this year created an Ad Hoc Special Task Force on Program, Principles, Structure, and Process (Task Force), and charged it with two assignments. The first, to define the major strategic directions the Society is to take for the next 3-5 years, and to identify and specify major program goals and priorities to undertake, to fulfill the strategic directions. The second task (possibly the much larger of the two), to recommend whatever modifications appear necessary to MMS' present governance structure and organizational function, to achieve the strategic direction, program goals and priorities established.

The composition of the Task Force was specified by the MMS Council, to consist of the MMS Executive board (Executive Councilors from each District, MMS Officers, MMS Executive Officers), the President of each District, and selected Committee Chairpersons, all chaired by the Council Speaker. Thus, the Task Force widely represented all the Districts of the MMS, in very much a "grass roots" manner.

The Task Force's first assignment, to define strategic direction, program goals and priorities, has been completed, reported to the MMS Council, and adopted (see Council Resolution October 14, 1992). As you will see, plans to undertake the next assignment are being made.

In tackling the first assignment, the Task Force first looked at how the MMS is viewed both by member MD's, non-member MD's, and selected other healthcare leaders/general public. The above were interviewed, questionnaired, etc. Those perceptions, correct or not, were remarkable for their degree of agreement; that the MMS is an inwardly focused organization, concerned only for its members' pocketbooks, reacting to rather than leading, its environment.

The Task Force then worked together to examine what MMS should be, where it should go, and how it should get there. By considering each member's views, suggestions, and priorities, the Task Force found the common themes unanimously espoused by all the participants, producing the resolves listed in the Council relolution (see below).

Ad we read the Strategic Direction statement, we see that much of it places more emphasis on new directions already being taken by MMS in recent years. This is a pleasing eye-opener, a grass-roots confirmation of multiple MMS initiatives in recent years, and also a mandate to continue the change in course, with greater conviction and determination than ever before. Note the dedication to the "interests of patients *and* physicians," to the "interests of *all* physicians," and note the recognition that "we will gain effectiveness through *public* support." Thinking back to the

perceptions of MMS referred to above, note the recognition of the "need to communicate clearly and effectively with its *members* and to the *public*."

By the conclusion of these processes, when all the membership has reflected on these directional philosophies, we will become a Society with a clear view of the future, and a strong common purpose. The concensus that began with the Task Force and spread to the General Council will emerge from the entire membership as well. The energy that could be unleashed and channeled into the Program Priorities listed is enormous, and will undoubtedly generate countless ingenious and creative initiatives for years to come. By developing public communication and education, public health and public service ititiatives, the MMS can earn the appreciation and respect of the Commonwealth. By promoting physician professionalism and development, physician advocacy and member services, we can attract our remaining non-member colleagues to the Society. Having earned the support of the Public, and the entire profession, we can be an effective voice in shaping the health care policy of the Commonwealth, to better serve the public, our patients.

We will count these efforts a success if the next time the profession and the public are asked to share their perceptions of MMS, the results will read: "The MMS is a public and professionally oriented, progressive organization that leads the way in promoting the health and welfare of the Commonwealth. ■

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The Massachusetts Medical Society Council Resolutions-October 14, 1992

RESOLVED, that the Massachusetts Medical Society (MMS) adopt the following statement on strategic direction:

"Over the next 3-5 years, MMS will become a more proactive organization.

We will continue to advocate for physicians recognizing the commonality as well as the diversity of the profession. The Society will continually seek out the common interests of all physicians and advocate for them.

In addition, MMS will also seek out and advocate for the common interests of patients and their physicians.

The Society will work to protect the professional autonomy of physicians and will take a leadership role in developing health care policy.

We will expand our role in educationg physicians and the public and we will gain effectiveness through public support.

In all that we do, The Society recognizes the need to communicate clearly and effectively with its members and to the public."

RESOLVED, that the Massachusetts Medical Society's (MMS) major areas of programmatic priority for the next 3-5 years are:

1. Physician Advocacy/Member Services
2. Health Care Policy
3. Communication
4. Outreach/Public Service/Public Health
5. Professionalism/Professional Development
6. Education

These areas of program priority are not intended to be exclusive of other appropriate program initiatives of the Society. They are, however, the higher-order areas of program priority which will need to be pursued in order to fulfill the commitment to the Society's strategic direction over the next 3-5 years.

RESOLVED, that the planning process to be employed to complete Stage II of the Society's review of programmatic priorities and organizational structures be as follows:

- The Ad Hoc Special Council Task Force on MMS Program, Principles, Structure and Process, the representative body of the Council established to complete Stage I of the planning process, will be responsible for the Stage II planning process and engage appropriate consutants as required.
- The planning process for Stage II shall commence after the Fall, 1992 Council meeting and be completed *prior* to the next annual meeting in May, 1993. If the Task Force can complete its work prior to the February, 1993 Council meeting, its report and recommendations can be made to the Council at this meeting. Otherwise, a Special Council meeting will be scheduled prior to the May, 1993 annual meeting to act on the Task Force's report and recommendations.
- The planning process for Stage II shall include:
  - broad input from membership
  - expert outside consulting advice on organizational and governance issues
  - an independent facilitator to manage the process
  - establishing a clear understanding of current organizational structures
  - District involvement, ideally prior to and following any planning retreats of the Task Force
  - an "inclusive, not exclusive process"; democratic in nature
  - a planning retreat of the Task Force (as required)
  - clear communication throughout the process
  - implementation to the Society's structures and functions. ■

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History of Cardiology in Western Massachusetts

Ralph Gianelly, M.D., is Chief of Cardiology at Baystate Medical Center. In the past ten years, he has presided over the growth and development of this division into one of the finest in New England. Remarkably, this has been done with an unprecidented collaboration between hospital-based and community-based cardiologists.

For many centuries, physicians have been fascinated by the cardiovascular system and studied it intensively. However, it was not until the 20th century that the specialty of cardiology came into being. The development of the electrocardiograph by Einthoven just after the turn of the century, the description of acute myocardial infarction by Herrick in 1912, and the herioc act of catheterization of his own heart by Forssmann in 1929 were among the major milestones leading to the creation of the subspecialty of cardiovascular disease. The American Board of Internal Medicine established the subpecialty board of Cardiovascular Disease in 1941. By the 1950's, cardiology was poised for explosive development. Open-heart surgery, coronary arteriography, artifical pacemakers, defibrillation, cardioversion, the coronary care unit and echocardiography were all introduced between the mid-1950's and the early 1960's.

"The story of cardiology in Western Massachusetts is an epic of continuing development and progress.

In Western Massachusetts there were physicians who focused on cardiology. The first was Dr. James Naurison, beginning in the 1930's. Soon thereafter he was joined by Drs. George Steele and Roderick Macauley. The major role of these physicians was to function as consultants and to perform and interpret electrocardiograms. A number of individuals followed in the same pattern of practice, including Dr. Jacob Weisman (Springfield Hospital). Drs. Frank Hurley and John Griffin (Mercy Hospital), and Drs. Donald Wetherbee, Samuel Klibanoff and William Coen (Wesson Memorial Hospital). Defibrillation and cardioversion became available here by the mid-1960's. Dr. Samuel Potsubay of Holyoke was one of the first to perform a cardioversion. In 1964, Dr. Jacob Shammash implanted the first permanent pacemaker ever done in our region.

The arrival of Dr. William Frankl from Temple University Medical Center in the summer of 1968 provided a major impetus to cardiology in Western Massachusetts. Dr. Frankl became the Chief of Medicine at Springfield Hospital, and he envisioned a cardiovascular medicine program which encompassed the full range of subspecialty services found in a university hospital. Soon after his arrival, he developed plans for a coronary care unit, as well as introducing echocardiography to Springfield Hospital. The coronary care unit was established in early 1969. Dr. Frankl recruited me as Chief of Cardiology and Dr. Jesse G. Hafer as Director of the Coronary Care Unit and the Noninvasive Laboratory. Dr. Hafer and I arrived in July, 1969. At the time, there were only five other members of the Springfield Hospital Staff in Cardiology who were active; Drs. Frankl, Weisman, and Griffin, as well as Drs. Stanley Teale and William Beachman. In addition to the physicians mentioned earlier, there were several who had a special interest in cardiology at other hospitals, including Drs. Mendel Mazer and Aloysius Bloniarz (Mercy Hospital), and Drs. Hugh Tatlock and Warren Fisher (Cooley Dickinson Hospital).

As soon as we arrived in the Summer of 1969, Dr. Hafer and I began the development of major services. Under my direct supervision, the cardiac catherization laboratory was opened in August, 1969. Dr. Hafer took responsibility for the recently created coronary care unit and noninvasive laboratory.

In 1970, we initiated the Fellowship Program in Cardiology with the recruitment of Dr. Alfonso Tiu, who is now practicing in Milwaukee. In 1972 we held our first annual cardiology symposium, and are now planning the 22nd in the series (to be held on April 2, 1993.) In 1974, we worked with the Administration and the Department of Surgery to submit a proposal for a cardiac surgical program to the Commonwealth of Massachusetts. We received approval in 1976, but implementation was delayed because of the merger of the Medical Center of Western Massachusetts (the successor to Springfield Hospital Medical Center) and the Wesson Memorial Hospital, resulting in Baystate Medical Center (April 1, 1976).

The Cardiac Surgical program was begun in February 1978 by Drs. Engelman and Rousou. In the same year we established a cardiac rehabilitation program under the supervision of Christopher Higgins. With the close collaboration of the Cardiology Division, Dr. Said Zubi initiated the program in nuclear cardiology in 1979.

Dr. Marc Schweiger joined the fulltime staff in 1977, and he subsequently became Director of the Cardiac Catheterization Laboratory. Under his leadership, we introduced coronary angioplasty in 1981. The service grew rapidly, and we now have a one-year training program for Fellows (4th year) in coronary angioplasty. Dr. Schweiger developed a strong interest in the role of thrombolysis in acute myocardial infarction and became the principal investigator at Baystate Medical Center for the TIMI 2 trial, a study which began in 1986 and which has powerfully influenced the management of patients with acute myocardial infarction. Baystate still participates in the TIMI trials which have continued to explore important questions related to thrombolytic therapy. In 1987 Dr. Mark Porway became Associate Director of the Cardiac Catheterization Laboratory and has worked as co-investigator in the TIMI trials. Dr. Alan Wiseman joined Drs. Schweiger and Porway in July, 1992.

Dr. James Kirchhoffer came to Baystate Medical Center in May, 1988, to initiate a program in Cardiac Electrophysiology. He also worked with the cardiac surgeons to make automatic implantable cardioverter defibrillators available to our patients, starting in 1988. The Electrophysiology Service grew rapidly, and Dr. James Cook was recruited as Associate Director in 1990. In the same year, Dr. Kirchhoffer introduced permanent pacemaker implantation as a service provided by cardiology at Baystate Medical Center (Dr. Edwin Wilder, a cardiologist at Franklin Medical

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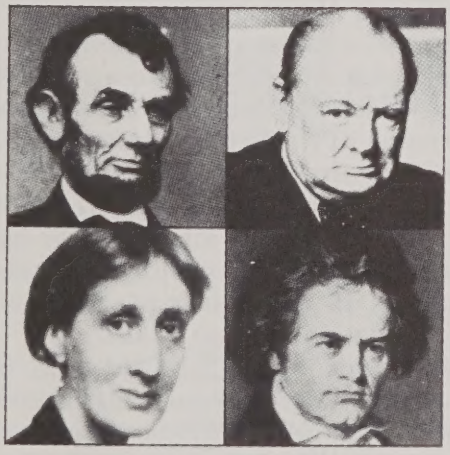

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History of Cardiology

Continued from previous page

Center, had been doing the procedure for a number of years). In 1991, Drs. Cook and Kirchhoffer brought to Baystate a new and exciting procedure which has revolutionized the treatment of supraventricular arrhythmias—catheter ablation. It is now possible, with a single procedure, to cure patients with supraventricular tachycardia, thereby eliminating troublesome and often dangerous arrythmas and freeing the patients from the risk and burden of lifelong antiarrhythmic drugs.

Noninvasive Cardiology at Baystate has undergone a major expansion in the past several years. Dr. Robert Rifkin was recruited to assume responsibility for the Noninvasive Laboratory in 1990. He reorganized the service and acquired essential equipment, including two new Hewlett-Packard echocardiographic systems. In 1991 he introduced transesophageal echocardiography to Baystate. He has also been performing intraoperative echocardiography to assist the cardiac surgeons. Under his guidance, a number of anesthesiologists have learned to perform certain echocardiographic procedures which aid in the monitoring of patients during surgery.

The community based members of the Cardiology Division have made essential contributions to the growth of our program. They are heavily involved in the teaching, both of the residents in Internal Medicine and the fellows in Cardiology. They provide a majority of the care for our patients, and they have a strong commitment to the progress of the Division. They participate extensively in the delivery of highly specialized services. In 1975, Dr. Stephen Wittenberg came from Buffalo to join Drs. Howard Ledewitz and Anthony Lovell. Until that time, only Dr. Hafer and I had performed cardiac catheterization procedures. We opened the laboratory to Dr. Wittenberg and assisted him as he developed a practice which has flourished. He and his associates subsequently recruited Drs. William Harbison, Thomas Marantz, and John Joelson, the latter two of whom also perform percutaneous transluminal coronary angioplasty. We now have fifteen community based physicians who perform cardiac catherization procedures. Among them are four doctors—Reed Shnider, John Zimmerman, J. Mark Peterman, and Joan Lisak—from Medical West Associates and a number who are active members of the staffs of neighboring hospitals including Mercy (Drs. Robert Chircop and Jay Markham), Noble (Dr. Shantilal Kenia), Cooley-Dickinson (Drs. Norman Perr and Mark Casey), and North Adams Regional (Dr. Douglas Herr). These physicians have created a network linking Baystate to its neighbors in a system which works to the benefit of all involved.

Including the fulltime physicians, the Cardiology Division now has more than 35 members. These individuals have worked in a collegial manner over nearly a quarter of a century to develop a very large program which, together with the cardiac units of neighboring hospitals, has served the needs of Western Massachusetts while providing training for hundreds of residents and fellows and conducting important research.

The Fellowship Program in Adult Cardiology at Baystate Medical Center has grown considerably in size and stature. Beginning with a single Fellow in 1970, we now have 9 in the program. We participate in the National Fellows Match and compete favorably with programs throughout the nation for candidates. Through June, 1992, 36 Fellows (4 of whom are still in training) had taken at least one year of training at Baystate Medical Center. Nineteen have taken all of their training at Baystate and are now in practice. It is especially gratifying to note that eight or our former Fellows are working in Western Massachusetts (Drs. Kenia, Porway, Peterman, Lisak, Herr, Wiseman, Ray and Khatak). Former fellows are now practicing in approximately fifteen states in all parts of the country.

Teaching and research go hand-in-hand, and we have progressively increased our research programs over the last decade. We have participated in studies of prediction of myocardial infarction in the emergency room and in systematic evaluation of our case fatality rate and treatment trends in acute myocardial infarction. We have studied antianginal, lipid lowering, and antiarrhythmic drugs, as well as new medications for treatment of congestive heart failure.

Each of the units within the Cardiology Division has developed its own particular interests. The electrophysiologists have evaluated intravenous amiodarone, sematilide, adenosine, and other investigational drugs. They have studied devices such as new types of pacemakers and defibrillators. They are analyzing heart rate variability as a prognostic factor in coronary artery disease. The invasive and interventional cardiologists are extensively investigating, as previously noted, thrombolytic therapy in myocardial infarction and ischemia. They have published studies of outpatient cardiac catheterization and multiple aspects of PTCA. Several members of the Cardiology Division participated in multicenter trials of lovastatin and pravastatin. We are also

testing amiodipine in patients with congestive heart failure and will be evaluating an angiotensin converting inhibitor, ramipril, in acute myocardial infarction. There are many other ongoing projects in the Division of Cardiology, and we will contine to enlarge the research effort.

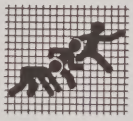
Elsewhere in Western Massachusetts, several hospitals have participated in multicenter trials of great importance. Noble Hospital recruited patients for ISIS 3 (International Study of Infarct Survival). Mercy Hospital and Mary Lane Hospital are actively involved in GUSTO (Global Utilization of Streptokinase and Tissue Plasminogen Activator for Occluded Coronary Arteries). The latter two trials have included 40,000 or more patients. These and other "megatrials" have in the last ten years become the standard method of deriving reliable results, and have provided a very firm foundation for treatment.

The cardiovascular disease program at Baystate Medical Center provides services for many thousands of patients every year. Nearly 3000 patients undergo cardiac catheterization, and more than 600 undergo open-heart surgery yearly. Thousands more are admitted for care or have specialized noninvasive tests. The relatively few physicians involved in administering this care would be utterly unable to cope without the dedicated work of a large support staff-technical, administrative, and secretarial. We are fortunate to have an abundance of talented professionals to provide these services. Our staff, of course, represents a small portion of the total needed for all of Western Massachusetts.

Another group which deserves very special mention is the Nursing Staff. Working in the Coronary Care Units and Telemetry Units in Western Massachusetts as well as the Cardiac Surgery Intensive Care Unit and Cardiac operating rooms at Baystate Medical Center are hundreds of specially trained nurses who provide the care to our patients. It is they who are the first to deal with any crisis, and who deliver the physical and emotional support to the patients and their relatives. They do it with the highest level of professionalsim and have earned our profound respect and affection.

The story of Cardiology in Western Massachusetts is an epic of continuing development and progress. The innovations which we physicians have been fortunate enough to introduce have dramatically improved outcomes for those afflicted with cardiovascular problems. We have been privileged to work with physicians in training, to watch them develop into respected colleagues and establish independent practices. For those of us who have participated in this journey, it has truly been a joy ride. ■

New directions



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Adult Cardiology Practice in the Second Half of the Twentieth Century

Stephen Wittenberg, M.D. contributed the following reflection on the changing face of cardiology. Steve conducts a busy private practice, and is a very popular teacher to the house staff and the cardiology fellows.

In the past several decades, a dazzling array of intellectual and technical changes have altered what the cardiologist sees and does and turned a rather 'ho hum' specialty into an ever changing action arena that taxes the skills of even the best trained and most diligent practioners. Disease patterns have changed. Rheumatic fever, once a common abnormality, occurs only in sporadic outbursts. Thus patients with rheumatic valvular diseases are less common. Meanwhile, calcific aortic stenosis, a disease of older people, is seen increasingly frequently. Mitral valve prolapse, seen mainly in younger patients, is recognized as common, with complications being uncommon but demanding the gamut of medical and surgical skills when they occur. The mortality from coronary artery disease has dropped dramatically. However, the patients who are rescued from catastrophe utilizing a variety of operative and catheter-based procedures and newer medical therapies re-emerge with new problems, each with a twist related to the salvage therapy. The cardiologist's landscape is kaleidascopic rather than a still life to be learned and practiced.

"Squashers, Scrapers, Burners, Breakers, Image Makers."

The major tools available to the cardiologist in the first half of the century were the stethoscope and the ECG. Electrocardiography hasn't changed much in the second half of the twentieth century, except that in many hospitals a computer does the reading and the cardiologist 'overreads.' The pivotal change occured with development of the ability to record intracardiac signals including atrial, His and ventricular potentials, and building on this, the capacity to do intracardiac stimulation in order to provoke, terminate and ablate dysrhythmias, as well as guide antiarrhythmic therapy. Rudimentary ventricular pacemakers have yielded to very sophisticated, programmable A-V sequential pacemakers. In the 1980's, the development of the AICD (automatic implantable cardioverter defibrillator) dramatically changed the approach to potentially lethal dysrhythmias. the practicing cardiologist today uses antiarrhythmic drugs sparingly and for very specific indications, often turning to the electrophysiologic laboratory for testing and device options. Electrophysiology itself has become the first sub/sub specialty of cardiology with a certifying examination.

The midpoint of this century also marked the beginning of a new era for cardiac hemodynamics. With Forssmann, Richards and Cournand's Nobel Prize winning development of cardiac catheterization in the 1940s and 1950s cardiologists were able to make precise hemodynamic measurements and cardiac surgeons began to devise corrective operations. Most physicians are aware of the landmark advances that built upon the ability to pass venous and arterial catheters, i.e. coronary angiography, percutaneous transluminal coronary angioplasty and most recently, as described in one text, the "crackers, breakers, stretchers, scrapers, shavers, burners, welders and melters" all aimed at relieving coronary and valvular stenoses. During the same period cardiac utlrasound has changed from a few barely interpretable signals into an exacting science able to image cardiac structure and blood flow with amazing accuracy.

No less important have been the medication advances since 1950. At mid century, cardiologists arrived with their four drugs, nitroglycerin, morphine, digitalis and a mercurial diuretic. Since then we have seen the development of multiple beta blockers, calcium blockers, ACE inhibitors, thrombolytic agents and following Brown and Goldstein's Nobel Prize winning work on lipid receptors in the 1980s a series of HMG-CoA reductase inhibitors which have finally given us hope of significant lipid lowering. Cardiologists and cardiac surgeons teamed up with immunologists to set the stage for cardiac transplantation.

To illustrate some of the changes in both medication and technology consider a cardiologist caring for the same acute myocardial infarction patient in 1960 and 1990. In 1960, Mr. X, a 50 year old patient presents to the emergency with 2 hours of severe chest pain unrelieved by NTG. The cardiologist pulls out his stethoscope and calipers. The heart sounds are soft and 'mushy.' The ECG suggests acute anterior myocardial infarction. The patient receives subcutaneous morphine, 02 by mask, and goes to a 'general medical floor.' The expected mortality is 30% with sudden cardiac arrest and congestive heart failure or shock being about equally likely. Mr. X must survive not only these medical complications but 1-2 weeks of forced inactivity including feeding by a nurse, the 'dangling' of the feet over the side of the bed, and finally after the first two weeks his first few steps. If there is post infarction angina or congestive heart failure, he may well be a cardiac cripple.

The same Mr. X in 1992 would arrive in the emergency room to a very different scenario. After a rapid screen for contraindications, he might receive a thrombolytic agent (TPA or SK) and perhaps be considered for a national trial of an even newer modality. He would go to a coronary care unit and receive standard regimens of heparin, beta blocker, magnesium, perhaps IV lidocaine and IV nitroglycerin. If the pain didn't abate, rescue angioplasty might be considered. The expected mortality would be down from 30% (1960) to 5%-10% (1992). If Mr. X did well, he would be walking on day 3, have a MUGA to assess ventricular function on day 4 and a ministress test on day 5 to screen for ischemia and direct him to home or to angiography. With the help of a cardiac rehabilitation program, the goal would be angina free, normal activity within weeks. If angina or congestive heart failure persisted, coronary angiography, angioplasty, coronary bypass surgery or even transplantation might be options.

Continued on next page

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Adult Cardiology Practice

Continued from previous page

If we watch the cardiologist at work in those two different settings, real differences are apparent. In 1960 we were expert physical diagnosticians and exacting electrocardiographers. Considerable time was spent listening to the heart, even acutely, and parsing the fine points of the ECG. However, no matter how accurate our assessment, we eventually sat holding the patient's hand while hoping for the best. Humane, but helpless, we did what little we could. In 1990, the cardiologist must move quickly and pragmatically, often supplementing ECG and a brief exam with echo and/or angiographic studies. There may be less early interpersonal time, but if things go well, the excitement of interventions may be followed by the satisfaction of seeing patient improvement. We can tell patients that restoration of normal function is a real possiblity. We act often with the uncertainty that has spawned many multicenter research trials and always with the rapid obsolescence of yesterday's ideas. We support one another with much team work and generally accepted protocols. Cardiologists have come to function more as teams and less as 'solo practioners.'

Whereas progress in cardiology in the second half of the 20th century has come mainly in the form of technical wizardry, many feel the first half of the 21st century will usher in an era of molecular biology. Genotyping has already begun to effect the way we approach diseases such as hypertrophic cardiomyopathy and congenital prolonged QT syndrome. Biochemical studies of endothelium are helping us understand the behavior of atherosclerotic plaques and the pathogenesis of restenosis. New knowledge about lipid metabolism may lead us to real prevention of coronary disease.

Today's cardiologist can choose from almost as many different fields as yesterday's newly graduated general physician. She/he can be a generalist specialist, helping the patient with overall cardiac care and steering the patient to the appropriate subspecialists. She/he can become an interventional cardiologist (a squasher or scraper), or an electrophysiologist (burner or breaker), or an ultrasound expert (image maker). Traditionally, cardiologists were the plumbers of internal medicine. Now, with the importance of blood coagulation, thrombolysis, tissue rejection and lipid metabolism, we have room for the chemists too. Only one thing is certain; everything will change! ■

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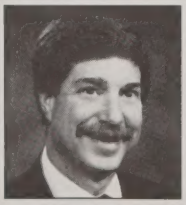

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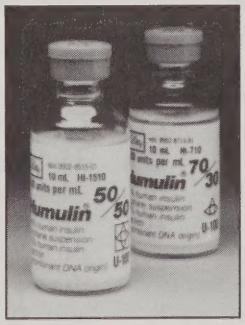

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Invasive and Interventional Cardiology

Mark Schweiger, M.D., is the Director of the Cardiac Catheterization Laboratory. Mark is Principal Investigator at BMC for the hugely successful and extremely important TIMI trials.

The field of invasive cardiology has undergone tremendous change over the past two decades. At Baystate Medical Center we performed approximately 350 cardiac catheterizations in 1977. In 1992 we would anticipate performing roughly 2800 such procedures. The field of invasive cardiology can be divided into two areas; diagnostic work and interventional work.

In 1977, 350 cardiac catheterization procedures were done at Baystate Medical Center. In 1992, about 2800 will be performed.

Diagnostic Catheterization:

The majority of patients that we see in 1992 are being evaluated for the presence and severity of coronary artery angiography and left ventriculography which enables us to diagnose the presence and extent of coronary artery disease as well as to make an accurate assessment of left ventricular function. Over the past number of years there has been improvement in the radiologic equipment such that the cineangiograms obtained have improved tremendously in quality. Additionally, newer x-ray stands have allowed us to obtain caudal and cranial oblique views so that we can see the coronary arteries in many additional views and therefore not miss critical narrowings.

Approximately 10% of our patients present with valvular, congenital or myopathic processes and in addition to evaluation of left ventricular function and coronary anatomy, these patients undergo a complete hemodynamic evaluation including a full right and left heart cardiac catheterization with cardiac outputs.

On the horizon, in the diagnostic field, catheterization systems are moving towards fully digitalized systems in which immediate playback in the digital mode will be performed enabling the physician to immediately see and diagnose the presence and extent of coronary disease. The unanswered question regarding digital technology is how these procedures will be archived with, at present, different companies having different archival ideas. Most cardiologists involved in invasive cardiology believe that most if not all labs will be fully digitalized within the next ten years.

Interventional Cardiology

There has been a tremendous growth in the field of interventional cardiology over the last 15 years since Andreas Gruentzig performed the first coronary angioplasty in 1977. The equipment available for angioplasty has undergone constant evolutionary changes so that our present balloons are extremely low in profile and are able to approach and dilate lesions that were felt impossible as recently as five years ago. When angioplasty is successful patients are able to leave the hospital, in general, within 24 to 48 hours and immediately resume full activities. The overall likelihood of success is approximately 95%. There remains approximately a 25 to 33% chance of the vessel renarrowing (restenosis) between 6 weeks to 6 months which would require an additional angioplasty procedure. When patients go beyond six months without restenosis, the risk of subsequent restenosis is no higher than 1%. At the time of angioplasty the major risk is that of vessel closure and approximately 2% of patients require urgent coronary bypass surgery. In addition to improvements in

angioplasty products the field has expanded in that many more acute myocardial infarction patients are brought right to the catheterization laboratory. At Baystate we tend to bring people to the cath lab who have had an acute infarction who do not appear to be responding to thrombolytic therapy, patients who are in shock, and some patients who are not candidates for thrombolytic therapy.

There are a number of new devices in the interventional cardiology field. The first nonangioplasty newer device is the directional crororary atherectomy. This device has a cutter which is pressed into the coronary narrowing by inflating a small balloon on the opposite side. The cutter then moves forward cutting the plaque and pushing it in the nose cone of the device. By turning the cutting surface one can direct this catheter. It was originally hoped that by cutting out the atheroma rather than blowing up a balloon and compressing it, that coronary restenosis would be reduced. To date there is no proof that restenosis is reduced however, the results of a large scale trial should be available by later 1992 or early 1993. The atherectomy device is useful in lesions which are eccentric, particulary in larger vessels. Many times, with eccentric lesions, the balloon catheter cannot achieve an adequate result while with atherectomy an excellent angiographic result can be obtained. As might be expected with any new device the atherectomy catheter is somewhat primitive, as were the initial angioplasty catheters. There are newer versions which are being released which are less bulky and would appear to increase the population of patients who may benefit from this procedure.

Intracoronary stents are another newer interventional device which appears to be on the verge of FDA approval. These metalic devices appear very useful in stabilizing the angioplasty patient with a bad result who would otherwise go emergently to bypass surgery. The intracoronary stent may also be useful for patients with a suboptimal angiographic result and is perhaps of use in reducing restenosis, particularly in patients with bypass grafts. The downside of the intracoronary stent is their propensity to develop acute occulusion a number of days later which obviously put patients at risk when they are out of the hospital. These patients require a very intense anticoagulation regimen. It seems that coronary stents will be of use in our interventional cardiology practice but it will be some time before their exact indications are clear.

Two other devices which are on the verge of being released are the coronary rotoblater and the coronary laser systems. The rotoblater is a small diamond shaped burr which rotates at tremendous speeds and basically ablates coronary narrowings. It appears to be of use in patients with smaller vessels, particularly those that are tortuous and lesions which are eccentric. There does not appear to be a reduced risk of restenosis; however, longterm randomized data addressing this question is not yet available. Intracoronary laser systems are available and appear to be useful in ostial lesions as well as in lengthy coronary narrowings. With both the rotoblader and laser systems a wire initially must cross the narrowing so that neither systems offers advantages in chronic total occlusions. The intracoronary laser does not appear to reduce restenosis and has a very large initial start up cost.

The field of interventional cardiology is advancing rapidly. The newer devices will most likely eventually occupy a nitch in our treatment of patients. Newer devices will not likely be an answer to the problem of restenosis which most likely will require pharmacological or DNA cloning tecnjologies. ■

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Wolf P. White, M.D.

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Hampden Committee Activities

David M. Chadbourne, M.D., brings us up to date on recent activities of our society.

The Executive Committee met on September 17th and received reports from our committees on some of the programs the committees have been working on.

The Public Relations Committee continues to work on future House Calls Programs. The next topic chosen will be Ophthalmology and sponsors are now being sought. Other topics being considered are Women's Health, Pediatrics and Infant Mortality covering children up to the age of one year.

The Public Health Committee will again sponsor the Anti-Smoking Poster Contest in the schools. This next contest will cover all of Hampden County and the posters will be displayed at Ingleside Mall in Holyoke. The contest will be held in the Spring of 1993. Our District Meeting was held at the Delaney House on September 22nd. A check for the Jane Doe Fund was presented to Dr. William E. Callahan, President of Massachusetts Medical Society and our speaker for the evening.

We again are very fortunate to have the new President-Elect of the American Medical Association accept our invitation to speak at our January 26, 1993 District Meeting. Dr. Joseph T. Painter will speak to us on Tuesday, January 26th and will address the Springfield Kiwanis Club Luncheon the 27th of January.

We have joined the Coalition For a Healthy Future which is sponsoring Question One on the November Ballot. This would increase the taxes on a pack of cigarettes by 25¢, with the monies raised by this tax increase to go to educating children against smoking. A Credentialing Breakfast was held on September 30th at the Ramada Hotel in West Springfield. All Hampden County hospitals were represented. Work was begun toward the goal of making it easier for physicians to renew their hospital credentials, hopefully using their birthday for renewal. An Implementation Committee will now be set up to work out the details.

On October 8th the Medico-Legal Committee held a joint dinner at Storrowton Tavern with the Hampden County Bar Association. With over a hundred physicians and lawyers attending, the meeting was a resounding success and could well become an annual event.

Our very active Medico-Religious Committee sponsored their Eighth Annual Medical Ethics Forum on October 14th with one hundred and twenty-five persons attending. Professor Joseph Healey of University of Connecticut's Medical School was the main speaker, addressing the topic-"Health Care Proxy—One Year Later". Evaluations showed this to be a very well accepted Seminar. ■

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Bruce Dziura, M.D. John P. Sullivan, M.D.

New Members Welcome

Maria E. Pina, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 27, 1961
Premed: Incarnate Word College 1979-1981
University of Arizona 1981-1984
Medical: University of Arizona 1985-1989
Internship: Baystate Medical Center
Residency: Baystate Medical Center 1989-Present
Specialty: Internam Medicine/Pediatrics
Resident

Niloufar H. Shoushtari, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: January 3, 1963
Premed: California State University 1983-1988
Medical: Tufts Medical School 1988-1992
Internship: Baystate Medical Center 1992-
Specialty: Internal Medicine
Resident

Barbara C. Carton, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 4, 1953
Premed: St. Francis Xavier University, Nova Scotia 1971-1975
Medical: Dalhousie Medical School, Nova Scotia 1978-1982
Internship: St. Joseph's Hospital, Ontario 1982-1983
Residency: Princess Margaret Hospital, Ontario 1989-1992
Victoria General Hospital, Nova Scotia 1988-1989
Specialty: Radiation Oncology

Jeffrey E. Gretz, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: February 6, 1960
Premed: SUNY at Stony Brook, NY 1978-1982
Medical: Eastern Virginia Medical School 1988-1992
Internship: Baystate Medical Center 1992-
Specialty: Internal Medicine
Resident

Paula Jo Carbone, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: November 22, 1963
Premed: Wesleyan University 1981-1985
Medical: University of Vermont 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-
Specialty: Internal Medicine
Resident

Lydia A. Kapell, M.D.
1111 Elm Street
West Springfield, MA 01089

Born: October 23, 1956
Premed: University of California at Santa Cruz 1974-1975
Hunter College, New York 1977-1980
Medical: State University of New York-Stonybrook 1980-1984
Internship: New York University Medical Center 1984-85 (Pediatrics)
Residency: Mt. Sinai Medical Center, NY 1985-1988 (Psychiatry)
Specialty: Psychiatry

Continued on next page

New Members Welcome

Continued from previous page

Barbara A. Faile
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: July 2, 1966
Premed: University of South Carolina 1984-1987
Medical: University of South Carolina School of Medicine 1988-1992
Internship: Baystate Medical Center 1992-
Specialty: Internal Medicine
Resident

Prasad G. Kilaru, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: August 4, 1966
Premed: Andhra Loyola College, India 1981-1983
Medical: Guntur Medical College, India 1983-1989
Internship: Baystate Medical Center 1991-1992
Residency: Baystate Medical Center 1992-
Specialty: General Surgery
Resident

Steven F. Reichert, M.D.
Baystate Medical Center
140 High Street
Springfield, MA 01199

Born: May 1, 1964
Premed: University of Michigan 1982-1986
Medical: University of Cincinnati 1986-1990
Internship: Baystate Medical Center 1990-1991
Residency: Baystate Medical Center 1991-
Specialty: Internal Medicine
Resident

Michelle L. Levy, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 9, 1959
Premed: Toledo University
Medical: Case Western Reserve University 1988-1992
Internship: Baystate Medical Center 1992-
Specialty: Pediatrics
Resident

Jay A. Hendrix, M.D.
2150 Main Street
Springfield, MA 01104

Born: November 16, 1956
Premed: Rice University 1975-1979
University of Texas 1980-1982
Medical: Southwestern Medical School 1982-1986
Internship: Yale New Haven Hospital 1986-1989
Residency: Baylor College of Medicine 1989-1992
Specialty: Dermatology/Internal Medicine

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The Last Word

On Clinical Trials

In about 1950, when even I was young, a friend's mother underwent a radical mastectomy for breast cancer. She had a pretty bad result; the arm became extremely swollen, and she had to wear it in a sling. Over the course of the next two years, since my mother was a nurse and talked aout these kinds of things at the supper table, (probably explaining the fact that my father was always painfully thin) I was aware that the disease had recurred, that she underwent an oopherectomy, then later, an adrenalectomy, neither of which seemed to do much. My last recollection of her was when my friend brought me into her bedroom to say hello, and later told me in a matter-of-fact voice that she was going to die soon. She did.

Since the 1950's we have learned that a radical mastectomy is not necessary, that you can predict who will respond to hormonal manipulation, that there are regimens which can improve cure rates after surgery, that there are chemotherapy combinations which greatly palliate patients and extend survival, that you don't need an operation to have effective hormonal ablation, and, perhaps quite applicable in this case, pain and suffering can be controlled by appropriate pharmacologic manipulation. (In the 1950's the mythology surrounding narcotics in this country was truly outstanding!)

The amazing progress in breast cancer management began in the early '70's when large scale randomized prospective trials attacked one issue after another, allowing us to make scientifically based statements, rather than basing our treatments on the clinical experience of our medical ancestors. Unfortunately, the proportion of patients entering clinical trials nationally as well as locally is declining rapidly.

In Health Region II, (where we live) patients have access to large scale NCI sponsored trials in just about every category of breast cancer you can name. Each trial is perfectly appropriate therapy for the patient who "fits the criteria". The more patients accessed to a trial, the quicker we will have answers for the next group of patients. Patients on clinical trials get *more attentive* follow-up on the average than those not on trials. Patients on clinical trials get the "investigational" parts of the trial covered by research funds. And contrary to popular opinion, most clinical trials are not really full of unnecessary tests (the message was heard loudly about five years ago by the various trial groups).

Why, then, are there so few patients in this region entering clinical trials—not just in the area of breast cancer, but thoughout all branches of medicine? It would seem to me that a physician has an obligation to seek the best treatment for his/her patients, and if the current treatments are not very good, to help hasten the day when better treatments are known. Trials are not a town-gown issue. Community physicians have served as principle investigators on a number of trials locally.

So what does all this mean to the practicing physician? I think it means being trial-oriented. Be aware of trials going on locally in the more common diseases you treat. When you send a patient to a consultant, ask the patient to ask about trials—it's been shown (at least among cancer specialists) that physicians give as the most common reason a trial was not suggested was the perception that the patient would not "understand" or "accept" a trial; but when trials were explained to patients who had already begun a course of "standard" therapy, most indicated that they were favorably disposed to a trial and would have considered going on a study if it had been mentioned.

The Halsted radical mastectomy was the treatment of choice for 60 years! Experimentation with breast sparing was reported a few months *before* the Halsted procedure was first described. Tens of thousands of women could have been spared this disfiguring and often crippling operation had clinical trials been done even two decades earlier. Will it be 60 more years before we make another major conceptual breakthrough in breast cancer? ■

Donald J. Higby, M.D.

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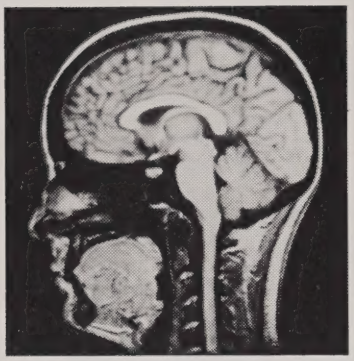

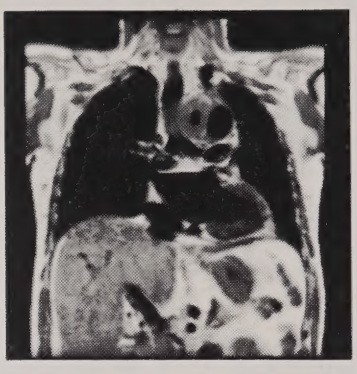

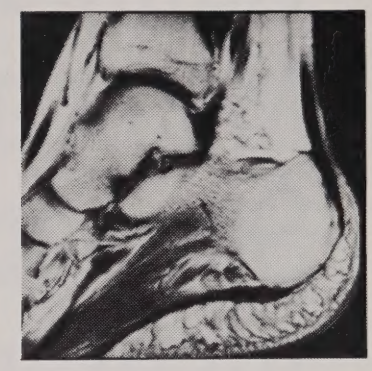

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